No. 06-410

IN THE

Supreme Court of the United States

DEBORAH R. BAUER AND DIANE G. WRIGHT,

Petitioners,

V.

ADVANCE PCS, PCS HEALTH SYSTEMS, INC., PCS MAIL SERVICES OF FORT WORTH, INC., AND PCS MAIL SERVICES OF BIRMINGHAM, INC.,

Respondents.

On Petition for A Writ of Certiorari to the Supreme Court of the State of Georgia

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BRIEF IN OPPOSITION

PAUL J. ONDRASIK, JR.
Counsel of Record
MARTIN D. SCHNEIDERMAN
ERIC G. SERRON
STEPTOE & JOHNSON LLP
1330 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 429-8088

Attorneys for Respondents

QUESTION PRESENTED

Whether the court below correctly applied to the particular facts before it the analytic framework for ERISA preemption set forth by this Court in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

RULE 29.6 STATEMENT

Respondents AdvancePCS, PCS Health Systems, Inc., PCS Mail Services of Fort Worth, Inc. and PCS Mail Services of Birmingham, Inc. are wholly-owned subsidiaries of Caremark Rx, Inc. ("Caremark"), a publicly held corporation. No publicly held company owns 10 percent or more of Caremark's stock.

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Respondents AdvancePCS, PCS Health Systems, Inc., PCS Mail Services of Fort Worth, Inc. and PCS Mail Services of Birmingham, Inc. (collectively "PCS") respectfully request that this Court deny certiorari.

STATEMENT

A. The ERISA Plans

Through their employers, petitioners participated in employee benefit plans that included a prescription drug benefit. Pet. App. 2.[1] Under the terms of the plans, petitioners are required to make co-payments for prescription drugs. *Id.* The amount of the co-payment turns on whether the medication is a "generic" drug or a "brand name" drug. Pet. App. 2, 40. Both plans defined generic and brand name drugs for these purposes. Pet. App. 2.

PCS manages the prescription drug benefits for the plans. It has separate contracts with the plan fiduciaries to provide these administrative services. Pet. App. 1. PCS is formally designated in the plans themselves as the "administrator" or "manager" of the prescription drug benefit. (R. 1650, 1696, 1704, 1885, 1886).

The plans at issue are governed by ERISA. Accordingly, both plans contain elaborate administrative review procedures, mandated by ERISA § 503, 29 U.S.C. § 1133 (2000), for participants to appeal any adverse benefit determination by PCS. Pet. App. 2. These procedures culminate in final review by the plan fiduciaries, who have full discretionary authority to interpret their respective plan's terms.

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[1] Although the two plans at issue contain minor differences in wording, their essential features are the same.

B. The Procedural History

In processing petitioners' prescription drug benefit claims, PCS treated the drug tamoxifen as a brand name, rather than a generic drug for purposes of the plans' co-payment provisions. Rather than challenging this benefit determination in the plans' ERISA-maintained internal review procedures, petitioners by-passed them entirely and instead filed a state tort action for unjust enrichment against PCS. Pet. App. 2. The gravamen of the complaint was that PCS had misapplied the terms of the plans in assessing the higher co-payment applicable to name brand drugs under the plans. Indeed, this was clear from the face of the complaint where they sought class certification to represent:

> All individuals who have been monetarily damaged by Defendants' mis-classification of tamoxifen as a brand named drug *when the medical plans covering them do not permit Defendants to classify tamoxifen as a brand name drug.*

Pet. App. 46 (emphasis added).

PCS removed the action to federal court, asserting that that the state law claim was "completely" preempted because it falls within the scope of ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (2000). That provision affords plan participants and beneficiaries a cause of action to obtain benefits or enforce rights under an ERISA plan. PSC argued that the state-law claim here was an attempt to enforce rights under the ERISA plan, because PCS's liability is dependent upon a showing that the plan participants are entitled to a generic co-payment for tamoxifen. The district court disagreed, believing that the analysis for complete preemption turned on whether the defendant is an ERISA fiduciary. Pet. App. 28-30. It remanded the case to the state court. Pet. App. 30.

On remand, PCS moved to dismiss the state court action under ERISA's express preemption provision, ERISA § 514(a), 29 U.S.C. § 1144(a) (2000). That provision states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. *Id.* The state trial court denied the motion to dismiss, but certified the order for immediate appeal. Pet. App. 31-34.

Thereafter, this Court issued *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). In *Aetna*, plan participants brought state law claims against HMOs for refusing to provide certain medical services under the ERISA plans. *Id.* at 205. The HMOs had separate contracts with the ERISA plan sponsors to administer the plans. *Id.* This Court announced that a state law action is completely preempted when: (1) the plaintiff could have originally brought her cause of action under ERISA's civil enforcement provisions and (2) no legal duty independent of ERISA or the plan's terms is violated by defendant. *Id.* at 210. In light of *Aetna*, PCS argued in the appellate court that Petitioners' state law claims were both expressly preempted by ERISA § 514(a) and impliedly preempted by the cause of action for plan benefits set forth in ERISA § 502(a)(1)(B).

The seven-member Georgia Court of Appeals was sharply divided over the application of *Aetna*'s two-part test to these facts. The majority found that the *Aetna* criteria was not satisfied and that the state law claim was not preempted by ERISA. Pet. App. 12-21.[2] Three judges dissented, noting

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[2] The majority also relied heavily upon *Morstein v. National Insurance Services, Inc.*, 93 F.3d 715 (11th Cir. 1996). That case involved a state law action against an insurance agent and agency for fraudulently representing that a replacement policy would provide the same coverage as the

(Continued ...)

that the "majority goes to great lengths to distinguish *Aetna*." Pet. App. 24. The dissent felt that *Aetna* was the controlling precedent because, in both *Aetna* and the case at bar, the plaintiffs were denied benefits based on the terms of their ERISA plans. Pet. App. 24.

C. The Supreme Court of Georgia's Decision

A unanimous Supreme Court of Georgia reversed. Pet. App. 1-30. Applying the analytical framework announced in *Aetna*, the court below found that petitioners' state law claim was preempted "[b]ecause plaintiffs' claims are dependent on the terms of their respective ERISA plans ..., and could have been raised in the context of ERISA's civil enforcement provisions." Pet. App. 1. The Supreme Court of Georgia relied upon ERISA §§ 514(a) and 502(a).

ERISA § 514(a). First, the court found that petitioners' state law claim "relates to" the plans at issue and therefore is expressly preempted by ERISA. Pet. App. 3-7. The court reasoned that the state law claim "depend[s] entirely on the language of their plans" and "whether that language entitled them to pay a generic co-payment for Tamoxifen." Pet. App. 4. As the court explained, PCS's liability is derived entirely from rights and obligations established by the plans:

> Plaintiffs' co-payment responsibility and entitlement exists only because the plans required plaintiffs to pay a specified amount for a generic drug and another amount for a brand name drug. Only if the plan entitles them to a generic co-

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existing policy for pre-existing conditions when, in fact, the replacement policy did not provide such coverage. *Id.* at 716-17. The Eleventh Circuit found that the state law claims were not preempted.

> payment for tamoxifen would their unjust enrichment claims against PCS have any merit.

Pet. App. 4.

The court rejected petitioners' attempt to distinguish this Court's precedent finding ERISA preemption. For example, petitioners argued that their claim is "not based on any improper denial of benefits." Pet. App. 4. The Supreme Court of Georgia disagreed: "plaintiffs' right to obtain a drug by paying a particular co-payment, which requires their plan provider to cover the remaining cost of the drug, is undeniably a plan benefit." *Id.*

The court below found "irrelevant" that PCS's classification of tamoxifen was not based on definitions in the plans. Pet. App. 5. The court explained that the "ultimate responsibility" for PCS's classification decisions "lies with the plan administrators." *Id.* If petitioners are entitled to the lower co-payment, then the "plan providers are obligated to provide the drug at that price regardless of any designation by PCS" and "any liability for the misclassification will be a contractual matter between PCS and the plan providers." *Id.*

The court also found irrelevant that PCS is not an ERISA fiduciary. Pet. App. 5. "'All courts of appeals to have considered the issue have held that ERISA preemption may apply regardless of whether the defendant is a plan fiduciary.'" *Id.* (*quoting Corcoran v. United HealthCare Inc.*, 965 F.2d 1321, 1330 n.13 (5th Cir. 1992)).

ERISA § 502(a). The state high court independently found implied preemption under ERISA § 502(a)(1)(B). Pet. App. 7-11. The court reasoned that the "two-part test from *Aetna* is satisfied in this case." Pet. App. 10. As for the first prong, the court found that petitioners "clearly" could have appealed the drug classification by PCS as a benefits denial under the plans and could have brought their claim under

Section 502(a) of ERISA seeking to enforce their rights under their plans. *Id.* As the court noted, the Department of Labor has indicated that plan participants "must be permitted to appeal co-payment assessments as a partial benefit denial under the claims procedures mandated by ERISA § 502(a)." *Id.* As for the second prong of *Aetna*, the court below found that the claim did not arise from any legal duty independent from the terms of their ERISA plans and thus the action was duplicative of an action for which ERISA provides the exclusive remedy. Pet. App. 10-11. "Plaintiffs have no unjust enrichment claim unless their plans entitle them to a generic co-payment." Pet. App. 10.

REASONS WHY THE PETITION SHOULD BE DENIED

The opinion of the Supreme Court of Georgia was unanimous. It was in complete accord with this Court's most recent decision on ERISA preemption in *Aetna* and plainly does not conflict with that or any of the Court's earlier preemption decisions. Nor does the decision below conflict with any decision of a federal court of appeals or another state court of last resort. Review by this Court is not warranted.

I. The Court Below Correctly Applied This Court's Recent Decision In *Aetna*

Petitioners argue (Pet. 14) that the Supreme Court of Georgia "misapplied the two-part test outlined in *Aetna*." An alleged misapplication of a correct legal standard to a particular case, however, does not ordinarily merit review by this Court. *See* Sup. Ct. R. 10 ("A petition for a writ of certiorari is rarely granted when the asserted error consists of * * * the misapplication of a properly stated rule of law."). Instead, "[a] petition for writ of certiorari will be granted only for compelling reasons" such as to resolve conflicting

decisions among state high courts or federal appellate courts on an important federal question. Sup. Ct. Rule 10(a). Here, petitioners have not alleged that the Supreme Court of Georgia applied *Aetna* in a way that conflicts with any lower court. Review is not warranted.

In any event, the court below correctly applied *Aetna*. Petitioners argue (Pet. 14) that the first prong in *Aetna* is not satisfied because they "could not successfully sue their health care plans under ERISA's civil enforcement provisions for the deliberate misconduct of PCS ...." As the court below noted, the Department of Labor requires that plan participants and beneficiaries be permitted to appeal any co-payment assessment as a partial benefit denial under the claims procedure mandated by ERISA § 502(a). Pet. App. 10. In *Del Greco v. CVS Corp.*, 337 F. Supp. 2d 475 (S.D.N.Y. 2004), *aff'd*, 164 Fed. Appx. 75 (2d Cir. 2006), a beneficiary sued the plan administrator under ERISA § 502(a), claiming that she was wrongfully required to pay a "brand name" rather than a "generic" co-payment when she purchased tamoxifen citrate. The district court found that Tamoxifen was properly classified as a "branded" drug for co-payment purposes under the terms of the health plans at issue, and therefore granted summary judgment in favor of the plan administrator. *Id.* at 491-98.[3] Petitioners need not have a "successful" claim under ERISA § 502(a) for preemption to apply, and they cannot use a state cause of

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[3] The same *Del Greco* plaintiff also brought a related ERISA action asserting similar claims against another defendant (Medco Health Solutions). The district court dismissed those claims too. *See Del Greco v. CVS Corp.*, 354 F. Supp. 2d 381, 386-87 (S.D.N.Y. 2005), *aff'd*, 164 Fed. Appx. 75 (2d Cir. 2006).

action to avoid the applicable standard of review in ERISA cases.[4]

As the court below further found, the second prong of *Aetna* is satisfied here because plaintiffs' claims do not arise independently of ERISA or the plan terms. Pet. App. 10-11. But for its obligation to process claims for prescription drug benefits under the Plans, PCS would have no relationship with petitioners. The plans at issue in this case not only direct participants to submit claims for prescription drug benefits to PCS, but also specifically define "generic" drug for purposes of determining applicable co-payments. As the court below found, petitioners "have no unjust enrichment claim unless their plans entitle them to a generic co-payment." Pet. App. 10.

A federal district court found complete preemption under ERISA § 502(a) on similar facts. *See Cooperstein v. Independence Blue Cross,* 36 Employee Benefits Cas. (BNA) 1666 (E.D. Pa. Aug. 2, 2005). The plaintiffs in that case alleged, among other things, that the defendant pharmacy benefit managers (including PCS) improperly charged them higher co-payments than they should have been charged due to incorrect coding of generic drugs as brand drugs and improperly prevented them from obtaining mail order discounts. As the *Cooperstein* court explained in finding that *Aetna* mandated preemption: "Plaintiffs essentially ask the Court to recover benefits withheld by Defendants and to enforce parts of their ERISA plan." *Id.* at 1673. That is

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[4] *E.g., Plumbing Indus. Bd., Plumbing Local Union No. 1 v. E.W. Howell Co., Inc.*, 126 F.3d 61, 69 (2d Cir. 1997) ("A suit need not be a cognizable, winning claim under § 502(a) in order to fall 'within the scope' of the provision for purposes of [jurisdictional] analysis.").

precisely what the petitioners seek here in asserting that they were deprived of the benefit of the plans' generic drug co-payment rate. Pet. App. 10-11.

Petitioners argue (Pet. 9-11, 13) that there can be no ERISA preemption here because they "do not sue their plans' administrator or fiduciary." In *Aetna*, the named defendants were not ERISA plans, but rather were managed care entities (HMOs) that contracted with the employers to provide administrative services to the ERISA plans. *Aetna*, 542 U.S. at 210-14; *see also Pegram v. Herdrich*, 530 U.S. 211, 227 (2000) ("[t]he HMO is not the ERISA plan"). Nonetheless, it made no difference for preemption purposes whether the ERISA plans were named as defendants. Rather, the question was whether, but for its obligation to provide administrative services for the ERISA plan, the HMO would have no relationship with the plaintiffs.[5]

There is no conflict among the lower courts on this issue. "'All courts of appeals to have considered the issue have held that ERISA pre-emption may apply regardless of whether the defendant is a plan fiduciary.'" Pet. App. 6 (quoting *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1330 n.13 (5th Cir. 1992)). More recently in *Jones v. LMR International, Inc.*, 457 F.3d 1174 (11th Cir. 2006), the Eleventh Circuit found that ERISA preempted the plan participants' state law claims against Great West Life & Annuity Insurance Company ("Great West"), which "performed services for the plan, including claims

[5] *See Aetna*, 542 U.S. at 211 ("the only relationship Aetna had with Davila was its partial administration of Davila's employer's benefit plan."); *id.* ("the only connection between Calad and CIGNA is CIGNA's administration of portions of Calad's ERISA-regulated benefit plan").

processing." *Id.* 1176. The court reasoned that, although Great-West was not a plan fiduciary, the claims asserted against it "'affect relations'" between the principal ERISA entities and plaintiffs. *Id.* at 1180 (citation omitted). "These claims thus are preempted regardless of whether Great West is an ERISA entity." *Id.*

Petitioners contend (Pet. 9, 13-14) that they do not claim a denial of ERISA benefits and that "their respective plans had nothing to do with [PCS's] misclassification." As the Supreme Court of Georgia found, petitioners' right to obtain a drug by paying particular co-payment "is undeniably a plan benefit." Pet. App. 4. *See also Heffner v. Blue Cross & Blue Shield of Alabama, Inc.*, 443 F.3d 1330, 1338 (11th Cir. 2006) ("not having to pay a deductible is a benefit of a plan"). The plans at issue not only direct participants to submit claims for prescription drug benefits to AdvancePCS, but also specifically define "generic" drug for purposes of determining applicable co-payments. These plan definitions of a "generic" drug establish unequivocally that petitioners' state cause of action is *not* independent of the plans' terms. *See Del Greco,* 337 F. Supp. 2d at 489-98 (claims administrator's assessment of a "branded" co-payment for tamoxifen citrate was not arbitrary and capricious under the plan's terms). As the court below found, "[o]nly if the plan entitles them to a generic co-payment for tamoxifen would their unjust enrichment claims against PCS have any merit." Pet. App. 4.

II. The Decision Below Does Not Conflict With This Court's Earlier Decisions

Petitioners argue (Pet. 11-13) that the decision below is inconsistent with this Court's pre-*Aetna* decisions recognizing a presumption against preemption in areas of traditional state regulation. The cases petitioners cite are demonstrably inapposite. *See* Pet. 12 (*citing, e.g., New York*

State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co., 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1997); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997)). In those cases, the Court held that state statutes of broad general applicability were not preempted by ERISA because they had only a speculative and indirect effect on the costs of health care services offered under certain ERISA plans. *E.g.*, *Travelers*, 514 U.S. at 668. These cases did not address causes of action seeking enforcement of an ERISA benefit plan brought under state law. In this case, by contrast, petitioners' state-law tort claims (if proven) would directly affect the benefits actually available under that ERISA plan. Pet. App. 4, 10-11.

Petitioners appear to believe that, in *Travelers*, the Court overruled or at least drastically modified its prior holdings including in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97 (1983). Pet. 9. However, the Court was careful to avoid that implication, expressing in *Travelers* its "fidelity to the views expressed in our prior opinions on the matter." *Travelers*, 514 U.S. at 668 (*citing Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983)).

The cases petitioners cite bear no resemblance to this case. *Travelers* addressed a state law that required hospitals to collect surcharges from patients covered by commercial insurers, but not from patients covered by a Blue Cross & Blue Shield plan. This Court held that the state law did not "relate to" ERISA plans within the meaning of § 514(a) because it did not require plan administrators to purchase any particular health insurance package. 514 U.S. at 659-60. The surcharge had merely an indirect economic effect on the relative costs of the various insurance packages available for purchase by plans, *id.*, which the Court described as "a far

cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans." *Id.* at 662.

Dillingham involved a statutory exception to the state's general wage law that permitted a public works contractor to pay workers in a state-approved apprenticeship program less than the prevailing wage. The Court described the effect of this statute as "substantially similar" to that of the surcharge program in *Travelers*. 519 U.S. at 334. It merely encouraged apprenticeship programs to meet the state's standards for approval, without requiring them to do so. *Id.* at 332-33; *see also id.* at 334 ("The prevailing wage statute alters the incentives, but does not dictate the choices, facing ERISA plans."). Thus, as in *Travelers*, the Court held that the statute did not "relate to" ERISA plans within the meaning of § 514(a). 519 U.S. at 334.

The issue in *De Buono* was whether ERISA preempted a state gross receipts tax on hospitals when applied to hospitals owned and operated by an ERISA plan. The Court found that the economic impact of this statute was no different than the surcharge program in *Travelers* — if the ERISA plan had chosen to purchase health care services from an independently run hospital, that hospital would have passed the expense of the gross receipts tax onto the plan through the rates charged for its services. 520 U.S. at 816. It was thus indistinguishable from the "'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of [§ 514(a)]." *Id.* at 815.

This case is distinguishable from *Travelers*, *Dillingham* and *De Buono*. As the court below found, petitioners seek direct enforcement of the provisions of their ERISA benefit plans, not through ERISA's exclusive enforcement provisions, but through state causes of action. The terms of the plans are the deciding factor in determining PCS's liability. There is no independent federal or state right to

have a differential co-pay for generic or brand name drugs, much less an independent federal or state right to have a lower co-payment for tamoxifen. Petitioners' co-payment responsibility (whatever it may be) exists only because *the plans* required petitioners to pay a specified amount to the pharmacy before the plans became obligated to pay the remaining cost of the drug.

Moreover, it is the very objectives and policy considerations behind ERISA that require preemption here. This Court has consistently applied ERISA's preemption to state laws that risk subjecting plan fiduciaries and administrators to a patchwork of conflicting state regulation. "Requiring ERISA administrators to master the relevant laws of the 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001) (alternations in original). In this litigation, petitioners bypassed the plans' ERISA-mandated internal appeal procedures that would have permitted the plan sponsors to interpret their respective plans. Petitioners instead sought to use state tort law to regulate the ERISA plans and entities. The plans at issue here are not unique; many plans outsource the initial processing of benefit claims to a third party whose decisions are subject to review by a plan fiduciary. Allowing petitioners to proceed on their state cause of action challenging PCS's initial co-payment assessments would undermine the exclusivity of ERISA's civil enforcement provision and expose ERISA plan fiduciaries, sponsors, and administrators in various states to different standards and conflicting state regulations. This type of activity is

prohibited by ERISA, and such prohibition is enforced by way of ERISA's preemption clause.[6]

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

PAUL J. ONDRASIK, JR.
Counsel of Record
MARTIN D. SCHNEIDERMAN
ERIC G. SERRON
STEPTOE & JOHNSON LLP
1330 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 429-8088

Attorneys for Respondents

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[6] The underlying benefit dispute in the case — whether tamoxifen is a generic or brand name drug — is now moot. PCS uses independent sources to classify tamoxifen. (Pet. App. 10). Those sources classified tamoxifen as a brand name drug during the time period at issue in the complaint because, due to patent restrictions on the drug, there were no generic manufacturers in the market. The patent has since expired, however, and tamoxifen is now classified as a generic drug.